ATTACHMENT D
AHCCCS DISPROPORTIONATE SHARE HOSPITAL PROGRAM
DSH 102

Congress established the Medicaid Disproportionate Share Hospital (DSH) program in 1981 to provide financial support to hospitals that serve a significant number of low-income patients with special needs.

This document sets forth the criteria by which Arizona defines DSH hospitals and the methodology through which DSH payments are calculated and distributed. The document is divided into the following major topics:

- Hospital eligibility requirements
- Data on a State Plan Year Basis
- Timing of eligibility determination
- Medicaid Inpatient Utilization Rate (MIUR) calculation (Overall and Group 1 eligibility)
- Low Income Utilization Rate (LIUR) calculation (Group 2 eligibility)
- Group 3 calculation (Group 3 eligibility)
- Governmentally-operated hospitals (Group 4 eligibility)
- Obstetrician Requirements
- Payment
- Aggregate Limits
- Reconciliations
- Certified Public Expenditures (CPEs)
- Grievances and appeals
- Other provisions

Eligibility Requirements

In order to be considered a DSH hospital in Arizona, a hospital must be a hospital located in the state of Arizona, must submit the form CMS 2552-96 (Medicare Cost Report) to the Center for Medicare and Medicaid Services, must submit the information required by AHCCCS by the specified due date, must satisfy one (1) of the conditions in Column A, AND must satisfy one (1) of the conditions in Column B, AND must satisfy the condition in Column C.

COLUMN A	COLUMN B	COLUMN C
1. The hospital has a Medicaid Inpatient Utilization Rate (MIUR) which is at least one standard deviation above the mean MIUR for all hospitals	1. The hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid	The hospital has an MIUR of at least 1 percent

receiving a Medicaid payment in the state ("Group 1") 1.A. The hospital meets all of the requirements of 1 above (Group 1) and is a privately owned or privately operated hospital licensed by the State of Arizona ("Group 1A") 2. The hospital has a Low Income Utilization Rate (LIUR) that exceeds 25% ("Group 2") 2.A. The hospital meets all of the requirements of 2 above (Group 2) and is a privately owned or privately operated hospital licensed by the State of Arizona ("Group 2A") 3. The hospital is a privately owned or privately operated acute care general hospital (psychiatric and rehabilitation facilities excluded) whose LIUR exceeds the mean LIUR for hospitals receiving Medicaid payments in the state *or* which provides at least 1% of the total Medicaid days across hospitals in the state ("Group 3") 4. The hospital is a governmentally-operated hospital ("Group 4")	patients 2. The hospital is outside a Metropolitan Statistical Area and has at least two (2) physicians with staff privileges to perform non-emergency obstetric procedures 3. The patients of the hospital are predominantly under 18 years of age 4. The hospital was in existence on December 22, 1987 but did not offer non-emergency obstetric services as of that date	

Notice that within Column A, there are six group numbers assigned. Group 1 and Group 2 contain those hospitals that are "deemed" to be DSH hospitals under federal Medicaid law. Group 1A, Group 2A, Group 3 and Group 4 contain additional hospitals that the state has designated to be DSH hospitals within its federal authority to do so. The criteria listed in Column B and Column C are federal eligibility requirements which apply regardless of whether or not the hospital is deemed or designated as a DSH hospital.

In Group 4, the term "governmentally-operated hospital" refers to a hospital provider which under federal law is able to participate in the financing of the non-federal portion of medical assistance expenditures. A governmentally-operated hospital is differentiated herein from "non-governmental", "non-public", "private", "privately operated" or "privately owned" hospitals as well as IHS or tribal or 638 hospitals and facilities as well as other federally owned or operated facilities. In order to participate in the financing of the non-federal portion of medical assistance expenditures under federal law, a health care provider must be operated by a unit of government as demonstrated from a showing of one of the following:

- The health care provider has generally applicable taxing authority
- The health care provider has direct access to generally applicable tax revenues
- The health care provider receives appropriated funding as a state university teaching hospital providing supervised teaching experiences to graduate medical school interns and residents enrolled in a state university in the state

Medicare Certification

In addition to the eligibility requirements outlined above, in order to receive payment under Medicaid, hospitals must meet the requirements for participation as a hospital in Medicare (except in the case of medical supervision of nurse-midwife services). Therefore, for purposes of DSH, the facility must be Medicare-certified during the state plan rate year for which the initial DSH payment is made.

If a facility is Medicare-certified for the full state plan rate year for which the initial DSH payment is made, but subsequently loses that certification, the facility remains eligible to receive the payment (together with any payment adjustments). If a hospital is only Medicare-certified for part of the state plan rate year for which the initial DSH payment is made, the eligibility and the payment will be calculated based on the period for which the hospital was Medicare-certified.

Data on a State Plan Year Basis

DSH payments are made based on the State Plan Rate Year. The State Plan Rate Year (or State Plan Year or SPY) is equivalent to the Federal Fiscal Year and runs from October 1 to September 30 of each year. The calculations to determine eligibility for, and the amount of,

DSH payments, will be made on the basis of the State Plan Year. This requirement will impact the information collected and submitted by all hospitals that do not have a fiscal year and/or CMS 2552 Report year that runs from 10/1 to 9/30.

In order to make the necessary calculations to determine eligibility and payments on a State Plan Year basis, hospitals that do not have a fiscal/CMS Report year that runs from 10/1 to 9/30 will have to submit cost reports and other data elements for each of the fiscal/CMS Report years that encompass the State Plan Year. For example, for SPY 2008 (10/1/07 to 9/30/08), for a hospital that has a CMS 2552 Report year that runs from 7/1 to 6/30, the hospital will have to submit the CMS 2552 Report and other data elements for the fiscal/CMS Report year that ends on 6/30/08 and the same information for the fiscal/CMS Report year that ends 6/30/09.[1]

As discussed later in this Attachment, AHCCCS will extract all Title XIX (Medicaid) claims and encounters from the PMMIS system on the basis of each hospital's CMS 2552 Report year and these data will serve as the basis for all Medicaid days, charges and payments. Similarly, AHCCCS will collect and distribute to hospitals all Medicaid supplemental payments (e.g. GME, Critical Access Hospitals (CAH), Rural Inpatient Payments) and Non-Title XIX payments (for Children Rehabilitative Services, the Comprehensive Medical and Dental Program, Behavioral Health Services and Payments for Trauma and Emergency Departments) on the basis of each hospital's CMS 2552 Report year.

All data compiled by the hospitals (e.g. total, uninsured and charity days; charges and payments; and state and local subsidy payment information not provided by AHCCCS) will be compiled on a CMS 2552 Report year basis.

Except in the case where a hospital's fiscal year is identical to the State Plan Year – the calculations to determine eligibility for, and the amount of, DSH payments, will be performed separately for each hospital's fiscal year and these results will be prorated based on the distribution of months from each of the two years that encompass the SPY. For example, for SPY 2008 (10/1/07 to 9/30/08), for a hospital that has a CMS 2552 Report year that runs from 7/1 to 6/30, the proration of the results of the calculations will be derived by summing:

1. $9/12^{th}$ of the result of the calculations performed for the fiscal/CMS Report year ending 6/30/08, and
2. $3/12^{th}$ of the result of the calculations performed for the fiscal/CMS Report year ending 6/30/09.

Timing of Eligibility Determination

[1] Note however that the use of the 2008 and 2009 reports and information referred to in this paragraph is for the determination of *final* DSH payments. For the initial 2008 DSH payments, reports and information for 2006 and 2007 will be submitted. For a discussion of initial payments, final payments and data sources, see the discussions that follow.

The eligibility determination calculations will be performed annually for all hospitals located in the State of Arizona that are registered as providers with AHCCCS. Eligibility calculations will be performed only with and for hospitals that have submitted the information required by this document and/or as otherwise requested by AHCCCS. In order to be considered "submitted", the information must be received by AHCCCS by the due date specified in a request for information communicated to the Chief Financial Officer of the hospital. The calculations will be performed with the information submitted by, or available to AHCCCS on the due date specified as the deadline for the submission of information.

The eligibility determination will be made in at least two steps:

1. The first step of the eligibility process will occur in the state plan rate year of the initial DSH payment. To determine initial eligibility, AHCCCS will:
    a. Extract from the PMMIS system all inpatient and outpatient hospital claims and encounters by date of service for each registered hospital for that hospital's fiscal years that encompass the state plan rate year two years prior to the state plan year of the initial DSH payment.
    b. Based on the extracted claims and encounters data and data provided by the hospitals, determine for each hospital whether or not that hospital has a Medicaid Inpatient Utilization Rate (MIUR) of at least 1%. For hospitals that qualify under this criteria, determine if the hospital:
        i. Meets the criteria for Group 1
        ii. Meets the criteria for Group 1A
        iii. Meets the criteria for Group 2
        iv. Meets the criteria for Group 2A
        v. Meets the criteria for Group 3
        vi. Meets the criteria for Group 4
    c. Based on certifications filed by each hospital, determine if the hospital satisfies the criteria in Column B above.

2. The second step of the eligibility process will occur in the state plan rate year two years after the state plan rate year of the initial DSH payment. To determine final eligibility, AHCCCS will:
    a. Extract from the PMMIS system all inpatient and outpatient hospital claims and encounters by date of service for each registered hospital for that hospital's fiscal years that encompass the state plan rate year of the initial DSH payment.
    b. Based on the extracted claims and encounters data and data provided by the hospitals determine for each hospital whether or not that hospital has a MIUR of at least 1%. For hospitals that qualify under this criteria, determine if the hospital:
        i. Meets the criteria for Group 1
        ii. Meets the criteria for Group 1A
        iii. Meets the criteria for Group 2
        iv. Meets the criteria for Group 2A
        v. Meets the criteria for Group 3

vi. Meets the criteria for Group 4

c. Based on certifications filed by each hospital, determine if the hospital satisfies the criteria in Column B above.

3. AHCCCS may redetermine any hospital's eligibility for any DSH payment should the agency become aware of any information that may prove that the hospital was not eligible for a DSH payment.

MIUR Calculation (Overall Eligibility Criteria and Group 1 and Group 1A Eligibility)

A hospital's Medicaid Inpatient Utilization Rate (MIUR) will determine the hospital's overall eligibility for DSH (Column C above) as well as the hospital's eligibility for Group 1 and Group 1A. A hospital's MIUR is calculated using the following equation:

$$MIUR = \frac{Total\ Medicaid\ Inpatient\ Days}{Total\ Number\ of\ Inpatient\ Days}$$

The calculation will be performed based on the state plan rate year. In order to find each hospital's MIUR for the state plan year, AHCCCS will calculate a MIUR separately for each hospital fiscal/CMS Report year that encompasses the relevant State Plan Year and then prorate the results from the two hospital fiscal/CMS Report years as described in the discussion above entitled "Data on a State Plan Year Basis".

If a hospital has a MIUR of at least 1%, and the obstetrical criteria of Column B above are satisfied, it will meet the overall eligibility criteria. If a hospital has a MIUR which is at least one standard deviation above the mean MIUR for all hospitals receiving a Medicaid payment, it will meet the eligibility for Group 1. If a hospital meets the eligibility criteria for Group 1 and is a privately owned or privately operated hospital licensed by the State of Arizona, it will meet the eligibility for Group 1A. NOTE that meeting overall eligibility criteria does not ensure that a hospital will meet the eligibility criteria for any Group.

In performing the calculations:

1. "Inpatient Days" includes:
    a. Fee-for-service and managed care days, and
    b. Each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward, and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

2. "Medicaid Inpatient Days" includes:
    a. All adjudicated inpatient days for categorically eligible Title XIX clients including days paid by Medicare except as noted below

b. All adjudicated inpatient days for waiver eligible Title XIX clients – that is clients that are eligible for Title XIX including days paid by Medicare and days funded by Title XXI except as noted below

3. "Medicaid Inpatient Days" does not include:
    a. Inpatient days in which a categorically or waiver eligible Title XIX client was in an Institution for Mental Disease (IMD) and the client was between 21 and 65 years of age

Data Sources for MIUR Calculations

1. For "Medicaid Inpatient Days" the PMMIS claims and encounters
    a. For the initial determination of a hospital's MIUR, extracted based on date of service for the hospital's fiscal/CMS Report years that encompass the state plan rate year that ends two years prior to the state plan rate year of the initial DSH payment.
    b. For the second determination of a hospital's MIUR, extracted based on date of service for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

2. For "Total Number of Inpatient Days" the CMS 2552-96
    a. For the initial determination of a hospital's MIUR, the cost report (or reports) for the hospital that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet S-3, Line 12, Column 6 plus Line 14, Column 6 for hospital subprovider days. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.
    b. For the second determination of a hospital's MIUR, the cost report(s) for the hospital that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet S-3, Line 12, Column 6 plus Line 14, Column 6 for hospital subprovider days. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

Calculation of the mean MIUR and the Standard Deviation

In calculating the mean MIUR, the MIUR calculated for the state plan year for all registered hospitals will be used. The mean MIUR – the average of the individual MIURs – will be calculated based on all the individual state plan year MIURs greater than zero (i.e. including the

MIURs that are less than 1%). The standard deviation will be calculated based on the same list of individual hospital MIURs.

LIUR Calculation (Group 2 Eligibility)

A hospital's Low Income Utilization Rate (LIUR) will determine the hospital's eligibility for Group 2. A hospital's LIUR is calculated by summing the following two equations:

$$LIUR = \frac{Total\ Medicaid\ Patient\ Services Charges + Total\ State\ and\ Local\ Cash\ Subsidies\ for\ Patient\ Services}{Total\ Charges\ for\ Patient\ Services}$$

$$+$$

$$\frac{Total\ Inpatient\ Charges\ Attributable\ to\ Charity\ Care - Cash\ Subsidies\ Portion\ Attributable\ to\ Inpatient}{Total\ Inpatient\ Charges}$$

The calculation will be performed based on the state plan rate year. In order to find each hospital's LIUR for the state plan year, AHCCCS will calculate a LIUR separately for each hospital fiscal/CMS Report year that encompasses the relevant State Plan Year and then prorate the results from the two hospital fiscal/CMS Report years as described in the discussion above entitled "Data on a State Plan Year Basis".

If a hospital has a LIUR that exceeds 25% it will meet the eligibility for Group 2. If a hospital meets the eligibility criteria for Group 2 and is a privately owned or privately operated hospital licensed by the State of Arizona, it will meet the eligibility for Group 2A.

In performing the calculations:

1. "Total Medicaid Patient Services Charges" includes Title XIX charges for inpatient and outpatient services (both fee-for-service and managed care)

2. "Total Medicaid Patient Services Charges" does not include DSH payments or payments made for GME, Critical Access Hospitals, Rural Inpatient Payments or any other TXIX supplemental payments authorized by the Legislature as these amounts are effectively included in charges

3. "Total State and Local Cash Subsidies for Patient Services" includes payments made with state-only or local-only funds and includes, but is not limited to
    a. Payments made for:
        i. Non-Title XIX and Non-Title XXI enrollees in the DES Comprehensive Medical and Dental Program
        ii. Non-Title XIX and Non-Title XXI enrollees in the DHS Children's Rehabilitative Services program

iii. Non-Title XIX and Non-Title XXI enrollees in the DHS Behavioral Health Services Program (note that these payments are typically made through Regional Behavioral Health Authorities)
iv. The support of trauma centers and emergency departments

b. Payments made by:
i. An appropriation of state-only funds
ii. The Arizona State Hospital
iii. Local governments including (but not limited to):
(1) Tax levies dedicated to support a governmentally-operated hospital
(2) Tax levies from a hospital district organized pursuant to A.R.S. § 48-1901 et seq.
(3) Subsidies for the general support of a hospital

4. "Total State and Local Cash Subsidies for Patient Services" does not include payments for or by:
a. Inpatient or outpatient services for employees of state or local governments
b. Governmentally-operated AHCCCS health plans or program contractors
c. Tax reductions or abatements

5. "Total Charges for Patient Services" includes total gross patient revenue for hospital services (including hospital subprovider charges).

6. "Total Inpatient Charges Attributable to Charity Care" includes the amount of inpatient services – stated as charges – that is provided free to individuals who cannot afford health care due to inadequate resources as determined by the hospital's charity care policy and do not otherwise qualify for government subsidized insurance. In order to qualify as charity care, payment may neither be received nor expected.

7. "Total Inpatient Charges Attributable to Charity Care" does not include bad debt expense or contract allowances and discounts offered to third party payors or self pay patients that do not qualify for charity care pursuant to the hospital's charity care policy.

8. "Cash Subsidies Portion Attributable to Inpatient" means that portion of "Total State and Local Cash Subsidies for Patient Services" that is attributable to inpatient services.

9. "Total Inpatient Charges" includes total inpatient and hospital subprovider charges without any deductions for contract allowances or discounts offered to third party payors or self pay patients.

Data Sources for LIUR Calculations

1. For "Total Medicaid Patient Services Charges":
a. For the initial determination of a hospital's LIUR:

i. The PMMIS claims and encounters extracted based on date of service for each registered hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.

b. For the second determination of a hospital's LIUR:
   i. The PMMIS claims and encounters extracted based on date of service for each registered hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

2. For the portion of "Total State and Local Cash Subsidies for Patient Services" and "Cash Subsidies Portion Attributable to Inpatient" attributed to Non-Title XIX and Non-Title XXI payments for the CMDP, CRS or Behavioral Health programs and for the payments in support of trauma centers and emergency departments:
   a. For the initial determination of a hospital's LIUR:
      i. AHCCCS will provide to hospitals the amounts of such payments made during the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment based on data from its financial records or from the financial records of the state agencies making the payments.
   b. For the second determination of a hospital's LIUR:
      i. AHCCCS will provide to hospitals the amounts of such payments made during the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment based on data from its financial records or from the financial records of the state agencies making the payments.
   c. In the case of CRS payments, if AHCCCS does not provide a breakdown of inpatient and outpatient payments, the hospital shall allocate the CRS payments between outpatient and inpatient based on the percentage of total inpatient charges to total charges for patient services

3. For all other "Total State and Local Cash Subsidies for Patient Services" and "Cash Subsidies Portion Attributable to Inpatient":
   a. For the initial determination of a hospital's LIUR:
      i. The hospital financial records for the payments received during the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
   b. For the second determination of a hospital's LIUR:
      i. The hospital financial records for the payments received during the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.
   c. In the case of "Cash Subsidies Portion Attributable to Inpatient", if the hospital receives subsidies for the general operation of the hospital, allocation between outpatient and inpatient should be based on the percentage of total inpatient charges to total charges from patient services.

4. For "Total Inpatient Charges Attributable to Charity Care":
    a. For the initial determination of a hospital's LIUR:
        i. The hospital claims and financial records for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
    b. For the second determination of a hospital's LIUR:
        i. The hospital claims and financial records for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

5. For "Total Inpatient Charges":
    a. For the initial determination of a hospital's LIUR, the cost report (or reports) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 6 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.
    b. For the second determination of a hospital's LIUR, the cost report(s) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 6 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

6. For "Total Charges for Patient Services":
    a. For the initial determination of a hospital's LIUR, the cost report (or reports) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 8 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be

deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

b. For the second determination of a hospital's LIUR, the cost report(s) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 8 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

Group 3 Eligibility Calculation

A privately owned or privately operated hospital's eligibility for Group 3 will be determined based on whether the hospital's LIUR exceeds the mean LIUR for all privately owned or privately operated hospitals receiving Medicaid payments in the state or whether the hospital provides at least 1% of the total Medicaid inpatient days provided by privately owned or privately operated hospitals. Psychiatric and rehabilitation facilities are excluded from consideration for eligibility in Group 3. The calculation of a hospital's LIUR is discussed above; presented below is the calculation of the mean LIUR and the calculation of a hospital's percentage of total Medicaid inpatient days

Calculation of the mean LIUR

In calculating the mean LIUR, the LIUR for all registered privately owned or privately operated hospitals will be calculated pursuant to the LIUR formula. The mean LIUR – the average of the individual LIURs – will be calculated based on all the individual LIURs greater than zero.

Percentage of Total Medicaid Days

A hospital's Medicaid Days Percentage is calculated using the following equation:

$$MedicaidDaysPercentage = \frac{Hospital\ Specific\ Medicaid\ Inpatient\ Days}{Total\ Medicaid\ Inpatient\ Days\ across\ All\ Hospitals}$$

In performing the calculations:

1. "Inpatient Days" includes:
    a. Fee-for-service and managed care days, and
    b. Each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward, and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

2. "Medicaid Inpatient Days" includes:
    a. All adjudicated inpatient days for categorically eligible Title XIX clients including days paid by Medicare except as noted below
    b. All adjudicated inpatient days for waiver eligible Title XIX clients – that is clients that are eligible for Title XIX including days paid by Medicare and days funded by Title XXI except as noted below

3. "Medicaid Inpatient Days" does not include:
    a. Inpatient days in which a categorically or waiver eligible Title XIX client was in an IMD and the client was between 21 and 65 years of age

4. "Total Medicaid Inpatient Days across All Hospitals" includes the total of "Medicaid Inpatient Days" for all privately owned or privately operated hospitals.

Data Sources for Medicaid Days Percentage Calculations

For the initial determination of a hospital's Medicaid Days Percentage, the data source is the PMMIS claims and encounters extracted based on date of service for each registered privately owned or privately operated hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment.

For the second determination of a hospital's MIUR, the data source is the PMMIS claims and encounters extracted based on date of service for each registered privately owned or privately operated hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

Group 4 Eligibility Determination – Governmentally-operated Hospitals

Because the state has designated all governmentally-operated hospitals (represented in Group 4) as DSH hospitals, no eligibility calculations are required. Instead, AHCCCS will determine DSH eligibility using the ''Tool to Evaluate the Governmental Status of Health Care Providers" published by the Centers for Medicare and Medicaid Services (CMS).

Obstetrician Requirements

In order to ensure that hospitals receiving DSH payments meet requirements related to obstetricians, all hospitals that are determined to have a MIUR of at least 1% must file a completed certification statement indicating their compliance with the requirements. Any hospital that fails to return the certification statement by the date specified by AHCCCS will not be eligible to receive DSH payments for the state plan rate year of the initial DSH payment.

For the determination of a hospital's compliance with the obstetrician requirement, the certification will be based on the state plan rate year of the initial DSH payment from the start of the state plan rate year to the date of certification.

The certification statement shall incorporate the following language:

> I certify that the hospital indicated below currently has and has had since the beginning of the current state plan year at least two (2) obstetricians with staff privileges who have agreed to provide obstetric services to individuals eligible for Medicaid, OR
>
> I certify that the hospital indicated below is located in a rural area and currently has and has had since the beginning of the current state plan year at least two (2) qualified physicians with staff privileges who have agreed to provide non-emergency obstetric services to individuals eligible for Medicaid, OR
>
> I certify that the hospital indicated below did not offer non-emergency obstetric services to the general population as of December 22, 1987, or that the inpatients of the hospital are predominantly individuals under 18 years of age.

Payment

Pools and Changing Payment Levels

The DSH program in Arizona is funded through a six pool system. Each of the pools correlates to one of the hospital eligibility Groups. Therefore, there are five non-governmental hospital pools and one governmental hospital pool. The non-governmental hospital pool amounts are set by AHCCCS as authorized by the Arizona Legislature; the governmental pool amount is established by the Arizona Legislature.

If a non-governmental hospital qualifies for more than one pool, the hospital will be categorized into the pool that maximizes its DSH payment. The payment amount to each non-governmental hospital will be determined based on the maximization process performed during the state plan rate year of the initial DSH payment. There are five instances where the initial DSH payment to one or more non-governmental hospitals may change:

1. A hospital is found on the second eligibility determination (or any subsequent eligibility check) to not be eligible for a DSH payment in the state plan rate year of the initial DSH

payment. In this instance, the amount of payment to the hospital will be recouped and the recouped amount will be distributed proportionately based on the initial DSH payments to the eligible hospitals remaining in the pool in which the ineligible hospital was placed in the state plan rate year of the initial DSH payment, up to each hospital's OBRA limit (see discussion below).

2. A hospital is found to have exceeded its finalized OBRA limit (see discussions below). In this instance, the amount of payment to the hospital in excess of its finalized OBRA limit will be recouped, and the recouped amount will be distributed proportionately based on the initial DSH payments to the eligible hospitals remaining in the pool in which the hospital was placed in the state plan rate year of the initial DSH payment, up to each hospital's finalized OBRA limit.

3. In the event of a recoupment of an initial DSH payment and as a result of the process of distributing the recoupment to the pool to which the recouped payment was originally made, the distribution would result in all the hospitals in the pool receiving a total DSH payment in excess of their finalized OBRA limit, the amount of recoupment will be proportionately allocated among the remaining non-governmental hospital pools based on the initial DSH payments and distributed proportionately based on the initial DSH payments to the hospitals in the remaining pools up to each hospital's finalized OBRA limit.

4. In the event that litigation (either by court order or settlement), or a CMS audit, financial review, or proposed disallowance requires AHCCCS to issue DSH payment amounts to one or more hospitals in a pool in excess of the initial DSH payment amount, AHCCCS will proportionately recoup funds based on the initial DSH payments from the remaining hospitals in the pool or pools effected to satisfy the requirement. This process will be followed to ensure that the annual federal DSH allotment is not exceeded.

5. In the event that a hospital qualifies for a DSH payment in the second (or any subsequent) eligibility determination that did not qualify in the initial eligibility determination, that hospital will receive the minimum payment under the DSH program which is $5,000.

The payment amount to each governmentally-operated hospital will be determined during the state plan rate year of the initial DSH payment. The payment amount will only change if the total DSH payment to a hospital in the pool would be in excess of its interim or finalized OBRA limit (see discussion below). To the extent that the excess amount recouped from a governmentally-operated hospital can be distributed to other hospitals in the pool without exceeding the interim or finalized OBRA limits of the remaining governmentally-operated hospitals, the excess amount will be distributed to the other governmentally-operated hospitals.

<u>Determination of Payment Amounts</u>

The amount that each non-governmental hospital receives as an initial DSH payment from the pool for which it qualifies is determined by a weighting method that considers both the amounts/points over the Group threshold and the volume of services. The volume of services is either measured by Title XIX days or net inpatient revenue, depending upon the group being considered.

Hospitals that only qualify for Group 1 or Group 2

There are ten steps to determining the DSH payment amount for non-governmental hospitals that only qualify for Group 1 or Group 2 (and not Group 1A, 2A or 3). After determining the initial DSH payment amount through the ten step process, there is a final adjustment that may be made depending on the result of the hospital's OBRA limit.

1. Determine Points Exceeding Threshold.
   Each of the Groups 1 and 2 has thresholds established for qualification of the hospital. For Group 1 it is one standard deviation above the mean MIUR; for Group 2 it is greater than 25% LIUR. Step 1 merely determines the difference between each hospital's "score" for the Group measure and that Group's threshold.

2. Convert Points Exceeding Threshold into a Value.
   Each of the Groups 1 and 2 are measuring a value: for Group 1 the value is Medicaid days; for Group 2 it is revenue. Step 2 multiplies the Points Exceeding Threshold by the value of the associated Group.

3. Determine Relative Weight of Each Hospital in Each Group.
   The relative weight of each hospital in each Group is determined by dividing each hospital's value for a Group determined in Step 2 by the total of all hospital values for that Group.

4. Initial Allocation of Dollars to Each Hospital in Each Group.
   The amount of funds available to each of the Groups 1 and 2 is determined by AHCCCS as authorized by the Legislature. The initial allocation to each hospital in each group is determined by multiplying each hospital's relative weight in a Group (determined in Step 3) by the amount of funds available for that Group.

5. Maximize Allocation of Dollars Between Group 1 and Group 2.
   This step selects the greater of the allocation to each hospital between Group 1 and Group 2.

6. Recalculating the Relative Weights of Each Hospital in Group 1 and Group 2.
   Since Step 5 eliminated hospitals from both Group 1 and Group 2, it is necessary to redetermine the weight for each remaining hospital. This is accomplished by dividing the value of each hospital remaining in Group 1 and Group 2 after Step 5 by the total of the remaining hospitals.

7. Second Allocation of Dollars Within Group 1 and Group 2.
   The second allocation to each hospital remaining in Group 1 and Group 2 is determined by multiplying each hospital's recalculated relative weight pursuant to Step 6 by the amount of funds available for that Group.

8. Identifying Minimum Payment.
   It is policy that the minimum payment made to any hospital qualifying for DSH is $5,000. This step identifies any amount thus far determined for any hospital that is less than $5,000.

9. Ensuring Minimum Payment.
   This step replaces any amount thus far determined for any hospital that is less than $5,000 with a $5,000 amount.

10. Determining Penultimate Payment Amount.
    With the replacement of values with the $5,000 minimum amounts, it is necessary to recalculate and redistribute the values within any Group where the minimum payment amount was imposed in order to ensure that the total funding for a Group is not exceeded. Step 10 accomplishes this.

After determining the penultimate initial DSH payment amount for each non-governmental hospital that only qualifies for Group 1 or Group 2 (and not Group 1A, 2A or 3) a check of the determined amount is made against the hospital's initial OBRA limit. The description of that limit follows in a subsequent section. If the initial DSH payment amount exceeds the initial OBRA limit, the initial DSH amount is set to the OBRA limit and the excess amount is distributed to the remaining hospitals in the group, with a recheck of the initial DSH amounts against the OBRA limit. This process is repeated until all amounts are distributed or all hospitals in the group are at their OBRA limit.

Hospitals that qualify for Group 1A, Group 2A or Group 3

There are thirteen steps to determining the DSH payment amount for non-governmental hospitals that qualify for Group 1A, 2A or 3. After determining the initial DSH payment amount through the thirteen step process, there is a final adjustment that may be made depending on the result of the hospital's OBRA limit.

1. Determine Points Exceeding Threshold.
   Each of the Groups 1A, 2A and 3 has thresholds established for qualification of the hospital. For Group 1A it is one standard deviation above the mean MIUR; for Group 2A it is greater than 25% LIUR; for Group 3 there are two thresholds: LIUR greater than the mean for hospitals receiving Medicaid payment in the state or more than 1% of the total statewide Medicaid days. Step 1 merely determines the difference between each hospital's "score" for the Group measure and that Group's threshold.

2. Convert Points Exceeding Threshold into a Value.
   Each of the Groups 1A, 2A and 3 are measuring a value: for Group 1A the value is Medicaid days; for Group 2A it is revenue; and for Group 3 it is either revenue or Medicaid days. Step 2 multiplies the Points Exceeding Threshold by the value of the associated Group. In the case of Group 3, the multiplier is net patient revenue.

3. Determine Relative Weight of Each Hospital in Each Group.
   The relative weight of each hospital in each Group is determined by dividing each hospital's value for a Group determined in Step 2 by the total of all hospital values for that Group.

4. Initial Allocation of Dollars to Each Hospital in Each Group.
   The amount of funds available to each of the Groups 1A, 2A and 3 is determined by AHCCCS as authorized by the Legislature. The initial allocation to each hospital in each group is determined by multiplying each hospital's relative weight in a Group (determined in Step 3) by the amount of funds available for that Group.

5. Maximize Allocation of Dollars Between Group 1A and Group 2A.
   This step selects the greater of the allocation to each hospital between Group 1A and Group 2A.

6. Recalculating the Relative Weights of Each Hospital in Group 1A and Group 2A.
   Since Step 5 eliminated hospitals from both Group 1A and Group 2A, it is necessary to redetermine the weight for each remaining hospital. This is accomplished by dividing the value of each hospital remaining in Group 1A and Group 2A after Step 5 by the total of the remaining hospitals.

7. Second Allocation of Dollars Within Group 1A and Group 2A.
   The second allocation to each hospital remaining in Group 1A and Group 2A is determined by multiplying each hospital's recalculated relative weight pursuant to Step 6 by the amount of funds available for that Group.

8. Selection of the Maximum Amount for Each Hospital.
   After having maximized each hospitals allotment between Group 1A and Group 2A and reallocating pool funding for each hospital remaining in each of the two groups (Step 7), a choice is made as to the highest amount for each hospital among Groups 1A, 2A, and 3.

9. Recalculating the Relative Weights of Each Hospital in Group 1A, 2A, and 3.
   In making the selection in Step 8, hospitals were removed from each of the three groups. This Step redetermines the weight for each remaining hospital in each of the three Groups. This is accomplished by dividing the value of each hospital remaining in each Group by the total value of the remaining hospitals in that Group.

10. Third Allocation of Dollars Within Group 1A, 2A, and 3.
    The third allocation of pool funds to each hospital remaining in each Group is determined by multiplying each hospital's recalculated relative weight pursuant to Step 9 by the amount of funds available for that Group.

11. Identifying Minimum Payment.
    It is policy that the minimum payment made to any hospital qualifying for DSH is $5,000. This step identifies any amount thus far determined for any hospital that is less than $5,000.

12. Ensuring Minimum Payment.
    This step replaces any amount thus far determined for any hospital that is less than $5,000 with a $5,000 amount.

13. Determining Penultimate Payment Amount.
    With the replacement of values with the $5,000 minimum amounts, it is necessary to recalculate and redistribute the values within any Group where the minimum payment amount was imposed in order to ensure that the total funding for a Group is not exceeded. Step 13 accomplishes this.

After determining the penultimate initial DSH payment amount for each non-governmental hospital that qualifies for Group 1A, 2A or 3 a check of the determined amount is made against the hospital's initial OBRA limit. The description of that limit follows in the next section. If the initial DSH payment amount exceeds the initial OBRA limit, the initial DSH amount is set to the OBRA limit and the excess amount is distributed to the remaining hospitals in the group, with a recheck of the initial DSH amounts against the OBRA limit. This process is repeated until all amounts are distributed or all hospitals in the group are at their OBRA limit.

Hospitals that qualify for Group 4

To determine the initial DSH payment amount for each governmentally-operated hospital, the relative allocation percentage for each hospital is computed based on the lesser of the hospital's OBRA limit and the amount of funding specified by the Legislature.

OBRA Limits

The DSH payment ultimately received by qualifying non-governmental hospitals is the *lesser* of the amount calculated pursuant to the above-described methodologies or the hospital's OBRA limit. The DSH payment ultimately received by governmentally-operated hospitals is the *lesser* of the amount funded and specified by the Legislature or the hospital's OBRA limit. All DSH payments are subject to the federal DSH allotment.

The OBRA limit is calculated using the following equation:

Uncompensated Care Costs Incurred Serving Medicaid Re*cipients* + *Uncompensated Care Costs Incurred Serving the Uninsured*

Pursuant to the above equation, the OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to individuals with no source of third party coverage for the inpatient and outpatient hospital services they received (uninsured costs).

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for each hospital up to three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment for all eligible hospitals based on the cost report(s) and days and charges and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment
2. For governmentally-operated hospitals, the OBRA limit will be recalculated when the cost report for the state plan rate year of the initial DSH payment is filed
3. The final calculation of each hospital's OBRA limit will be performed when the cost report for the state plan rate year of the initial DSH payment is finalized

The steps to computing the OBRA limit are[2]:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). Each hospital must complete the cost report to determine per diems (for inpatient routine services) and ratios of cost to charges (RCC) (for ancillary services). The cost reports must be completed based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.
2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and charges and other program data collected by each hospital from its claims and financial records, other systems, and the cost report.

The sum of each hospital's Medicaid shortfall (whether positive or negative) and uninsured costs (whether positive or negative) is that hospital's OBRA limit.

[2] Note: The following discussion applies to hospitals that do not have a per diem ancillary allocation methodology approved by Medicare. For the steps to calculate the OBRA limit for governmental hospitals that do have such approval, see Exhibit 2 to this Attachment D. Non-governmental hospitals that have such approval should contact AHCCCS for further information.

The Medicaid Shortfall

The data used to calculate the Medicaid shortfall is extracted from the cost report(s) as well as from the AHCCCS PMMIS system and other AHCCCS financial reporting systems. The Medicaid shortfall will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting Medicaid shortfall for each fiscal/CMS Report year will be prorated to derive the state plan year Medicaid shortfall according to the above discussion entitled "Data on a State Plan Year Basis".

The information from AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
2. The number of Medicaid managed care inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
3. The Medicaid inpatient and outpatient hospital FFS charges for ancillary cost centers (for governmentally-operated hospitals this will be accumulated separately for each ancillary cost center on the cost report)
4. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital FFS services
5. The amounts of Medicaid payments made by AHCCCS for inpatient and outpatient hospital FFS services
6. The Medicaid inpatient and outpatient hospital managed care charges for ancillary cost centers (for governmentally-operated hospitals this will be accumulated separately for each ancillary cost center on the cost report)
7. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services for health plans and program contractors
8. The amounts of Medicaid payments made by health plans and program contractors for inpatient and outpatient hospital services for health plans and program contractors
9. Other amounts of Medicaid payments for Medicaid inpatient and outpatient services furnished during the Medicaid state plan rate year under review (e.g. GME, CAH, etc.)

For each non-governmental hospital the all payor per diem and ratio of cost to charges (RCC) from the cost report will be applied to the data extracted from PMMIS (days and charges) to determine the cost of providing inpatient and outpatient Medicaid services. Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services. The per diem amount will be calculated by dividing:

- The sum of the amounts on Worksheet B Part 1 Column 25 Lines 25 to 33 less the amounts appearing on Worksheet D-1, Part I Lines 26 and 36
- By

- The sum of the amounts on Line 12, Line 14 (for inpatient hospital subproviders), and Line 26 (for observation bed days) from Worksheet S-3 Part I Column 6.

The ancillary RCC will be calculated by dividing:

- The sum of the amounts on Worksheet B Part 1 Column 25 Lines 37 to 63, less Lines 63.5 to 63.99 , (Note: if costs for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these cost amounts should also be deducted.)
- By
- The sum of Lines 37 to 63, less Lines 63.5 to 63.99, from Worksheet C Part I Column 8. (Note: if charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted.)

For each governmentally-operated hospital the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report will be applied to the data extracted from PMMIS (days and charges) to determine the cost of providing inpatient and outpatient Medicaid services. Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services. The per diem amounts will be calculated by dividing:

- The individual amounts on Worksheet B Part 1 Column 25 Lines (and where applicable Subscript Lines) 25 to 33
- By
- The corresponding day totals on Lines (and where applicable Subscript Lines) 5 through 11 and Line 14 (for inpatient hospital subproviders) from Worksheet S-3 Part I Column 6.

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary RCCs will be calculated by dividing:

1. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet B Part 1 Column 25
2. By
3. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet C Part 1 Column 8

Costs will be offset by the payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services as well as payments made by AHCCCS including FFS payments, payments by health plans and program contractors, and supplemental payments (such as GME, Rural Hospital Payments and CAH) made during the hospital's fiscal/CMS Report years that encompass the state plan rate year.

Uninsured Costs

Each hospital will collect uninsured days and charges and program data for the hospital's fiscal/CMS Report years that encompass the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient and outpatient days and charges and program data for medical services that would otherwise be eligible for Medicaid should be included in the DSH calculation. Inpatient and outpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days, charges and program information provided to the state is subject to the same audit standards and procedures as the data included in the cost report.

When providing uninsured days, charges and program information hospitals should be guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

When submitting uninsured days, charges and program information hospitals should accompany the submission with:

- A listing of all payor types that are included in the uninsured data compilation, and

- A CD or DVD that contains sufficient claims or other information (e.g. ICNs) to enable an auditor to tie the amounts submitted to the financial records of the hospital

The uninsured costs will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting uninsured costs for each fiscal/CMS Report year will be prorated to derive the state plan year uninsured costs according to the above discussion entitled "Data on a State Plan Year Basis".

The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
2. The uninsured inpatient and outpatient hospital ancillary charges (for governmentally-operated hospitals this will be accumulated for each ancillary cost center on the cost report)
3. The amounts of payments received during the hospital's fiscal/CMS Report years that encompass the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services. The information collected shall:
    a. Include payments received during the hospital's fiscal/CMS Report years that encompass the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,
    b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

For each non-governmental hospital the all payor per diem and ratio of cost to charges (RCC) from the cost report (as determined for Medicaid) will be applied to the data collected by the hospital to determine the uninsured costs.

For each governmentally-operated hospital the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report (as determined for Medicaid) will be applied to the data collected by the hospital to determine the uninsured costs.

Costs will be offset by the payments received during the state plan year from or on behalf of patients and payments received during the hospital's fiscal/CMS Report years that encompass the state plan year from third parties related to all uninsured inpatient and outpatient hospital services. Payments made by state or local government are not considered a source of third party payment.

The OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit.

Aggregate Limits

IMD Limit

Federal law provides that aggregate DSH payments to Institutions for Mental Diseases (IMDs) in Arizona is confined to the *lesser* of $28,474,900 or the amount equal to the product of Arizona's current year total computable DSH allotment and 23.27%. Therefore, DSH payment to IMDs will be reduced proportionately to the extent necessary to ensure that the aggregate IMD limit is not exceeded.

"Institutions for Mental Diseases" includes hospitals that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

Overall Total Limit

The federal government shares in the cost of Medicaid DSH expenditures based on the Federal Medical Assistance Percentage (FMAP) for each state. However, for each fiscal year, the amount of federal funds available to states for DSH payment is fixed. As such, the total amount of DSH payments for a state plan rate year will not exceed the federal allotment divided by the FMAP.

Reconciliation

The initial DSH payment issued to a hospital by AHCCCS is considered "interim" and is subject to different reconciliation methodologies depending upon whether the hospital is non-governmental or governmentally-operated. The payments to hospitals are generally made as a single lump sum payment that is made once the calculations of the payment amounts are completed. The purpose of the interim DSH payment is to provide reimbursement that approximates the Medicaid and uninsured inpatient hospital and outpatient hospital uncompensated care costs eligible for Federal Financial Participation (FFP).

The reasons for a change in the initial (or interim) DSH payment for both non-governmental and governmentally-operated hospitals are outlined above under "Pools and Changing Payment Levels".

If it is determined that the total amount of payments made to non-governmental hospitals under the methodology outlined in the "Pools and Changing Payment Levels" exceeds the amount of all finalized non-governmental hospital OBRA limits, the amount in excess will be recouped by

AHCCCS and any associated federal funding claimed will be properly credited to the federal government.

If it is determined that the total amount of payments made to governmentally-operated hospitals under the methodology outlined in the "Pools and Changing Payment Levels" exceeds the amount of either:

1. All governmentally-operated hospital OBRA limits calculated based on the "as filed" cost reports, or
2. All governmentally-operated hospital OBRA limits calculated based on the "finalized" cost report, or
3. The total amount of certified public expenditures of governmentally-operated hospitals, then
4. The amount in excess will be recouped by AHCCCS and any associated federal funding claimed will be properly credited to the federal government.

Certified Public Expenditures

Expenditures by governmentally-operated hospitals shall be used by AHCCCS in claiming FFP for DSH payments to the extent that the amount of funds expended are certified by the appropriate officials at the governmentally-operated hospital.

The method for determining a governmentally-operated hospital's allowable uncompensated care costs eligible for DSH reimbursement when such costs are funded through the certified public expenditure (CPE) process will be the same as the method for calculating and reconciling the OBRA limit for governmentally-operated hospitals set forth above. However, in order to use CPE, the certifying governmentally-operated hospital must follow the protocol in Exhibit 1 and provide a certification as to the amount of allowable uncompensated care costs eligible for DSH reimbursement. If CPE is used, the amount of expenditures used to determine the FFP will not exceed the amount of the CPE.

The payment of FFP to governmentally-operated hospitals is subject to legislative appropriation.

Grievances and Appeals

The state considers a hospital's DSH eligibility and DSH payment amount to be appealable issues. A DSH eligibility list along with the initial DSH payment amounts that eligible hospitals have been calculated to receive will be distributed. Hospitals will be permitted thirty (30) days from distribution to appeal their DSH eligibility and payment amounts. Because the total amount of DSH funds is fixed, the successful appeal of one DSH hospital will reduce DSH payment amounts to all other providers. Once the final reconciliation process is completed, no additional DSH payment will be issued.

Other Provisions

Ownership

DSH payment will only be issued to the entity which is currently registered with AHCCCS as a participating hospital provider. Therefore, it is expected that facilities will consider this information when negotiating ownership changes.